Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
SPECIALIST PSYCHOTHERAPY SERVICE (SPS)

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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*Oct 2023*	*New SOP. Approved at MH Division Clinical Network (4 October 2023).*

Contents

1. INTRODUCTION

Humber Teaching NHS Foundation Trust provides Specialist Psychotherapy Services (SPS) as part of a pathway of community based mental health services for the city of Hull and the East Riding of Yorkshire. The Specialist Psychotherapy Service (SPS) forms a part of the Complex Interventions Service (CIS), alongside Humber Traumatic Stress Service (HTSS) and the Mentalization Based Treatment Service (MBTS). The SPS provides consultation, supervision, assessment, specialist interventions, and joint working for service users with severe and complex mental health presentations.

The team works closely with key stakeholders external to the organisation including service users and carers, primary care services, and other local statutory and non-statutory agencies, to deliver responsive care that meets the need of the population.

We are committed to providing high quality care. The team will assess and treat the majority of service users at the aforementioned base in Hull. Based on clinical need, service users can be seen online or at a locality base provided this can be facilitated operationally. SPS strive to function in a timely and responsive manner to our local communities.

2. SCOPE

This Standard Operating Procedure (SOP) describes the functions of SPS and outlines how the team will manage referrals for consultation, assessment, and therapeutic intervention. This document is aimed at all staff members working with the service, including students, agency staff or non-employees of the Trust, such as contractors.

3. DUTIES AND RESPONSIBILITIES

The Board of Directors
The Board of Directors is responsible for ensuring that the organisation consistently follows the principles of good governance applicable to NHS organisations. This includes the development of systems and processes for clinical risk assessment and management.

Chief Executive
The Board of Directors delegates to the chief executive the overall responsibility for ensuring the trust employs a comprehensive strategy to support the management of risk, including clinical risks associated with patient care.

Service Manager, Service Lead, Senior Clinical Psychologists and Team Lead
The service manager and the service lead are responsible for the implementation of policy, procedures, and training for relevant staff groups in their areas of responsibility. It is the responsibility of the senior leadership team (service lead, senior clinical psychologists, and team lead) to review referrals and waiting lists on a weekly basis to provide assurance regarding the validity of information and effective implementation of this Standard Operating Procedure. It is also the role of the senior leadership team to facilitate the day to day clinical leadership and operational management to support the service in providing responsive and timely packages of care and for monitoring waiting times within their operational structures. Where factors adversely affecting waiting times are identified, they will act to escalate these as swiftly as possible to the Service Manager and Service Lead.

The senior leadership team will work closely with corporate support services, in particular the performance team, to provide a clear line of sight for the Trusts senior management team regarding any emerging pressures within the service.

Information and Performance Management Teams
It is the responsibility of the Information and Performance Management Teams to provide insights in relation to business intelligence which will include regular performance reports, technical advice, systems support and tools to ensure SPS are able to manage referral to treatment pathways in an effective and efficient manner.

Employees
All employees will familiarise themselves with the scope of this document and where relevant to their role, comply with this standard operating procedure.

4. STRUCTURE

The team staffing comprises:

Service Lead (Consultant Clinical Psychologist)
Highly Specialist Clinical Psychologists
Psychotherapists
Trainee Psychotherapist
Team Lead/ Case Manager
Administrative support

Operational management functions are overseen by the service manager and delegated to the Team Lead to fulfil where appropriate.

The team also provide training and learning opportunities to other clinicians not substantively employed by SPS (e.g. trainee clinical psychologists, junior doctors). In these instances the clinical responsibility for the training and learning period is with the allocated clinical supervisor, with the trainee to maintain their professional codes of conduct and practice within their scope of proficiency.

5. CONTACT DETAILS

Specialist Psychotherapy Service - Complex Interventions Service
77 Beverley Road,
Hull,
HU3 1XR

Tel: 01482 689156

Email hnf-tr.complexinterventionsservices@nhs.net

6. HOURS OF OPERATION

The service will operate Monday to Friday, 09.00-17.00, with some flexibility of these times to meet patient need.

7. PROCEDURES

7.1. Referrals

Each of the three teams in the CIS has their own referral criteria guided by service specifications advised by the Integrated Care Board (ICB). SPS referrals are currently received by the individual teams and discussed within the weekly CIS referral multidisciplinary team (MDT) meeting.

Referrals are allocated based on clinical need and the remit of each of the clinical teams within the CIS.

Currently, the service is only able to accept referrals from Humber NHS Foundation Trust internal mental health services. However, it is hoped that a stronger interface with primary care providers can be developed to support a step-up and step-down system aligned with the transformation of community mental health services.

All referrals into the service will be received via an electronic referral made on Lorenzo, except in the case of services which do not share the same clinical system. These services will be encouraged to contact the SPS to arrange a clinical discussion for consultation; sharing relevant clinical correspondence and information to upload to the clinical system.

The referring service should not close their referral until a decision has been made in relation to the referral created to the SPS. This is to support a safe feedback mechanism so that the needs of the service user are not lost in between accessing services, and to support the service user navigating to the most suitable alternative clinical pathway, where indicated.

Exceptions: Out of area Care Program Approach (CPA) transfers, where the individual is already under the care and treatment of specialist mental health services or, as a minimum, who have a robust treatment plan in place, may be accepted without having been through the trusts own internal pathways as detailed above, subject to review by the SPS.

7.1.1. Referral pathways

As an operational procedure, this document sets out to define and outline the pathways of newly referred service users into the Specialist Psychotherapy Service. This pathway will include referral screening and consultation, assessment and decision for treatment or referral on by clinicians.

7.1.2. Referral criteria

Consultation is available to any clinician working with an adult presenting with what is recognised as a complex presentation in the mental health division.

We ask that all referrals include the following, where applicable:

- Full secondary mental health assessment or appropriate alternative
- Up to date clinical risk assessment completed on a Trust approved tool
- Up to date patient demographical information – including next of kin
- Up to date Patient Reported Outcome Measures (PROMS) i.e. ReQoL10, Goal Based Outcome Measure and DIALOG.

Whilst the SPS do not have referral exclusion criteria, there are factors which need to be carefully considered in relation to whether an exploratory therapeutic intervention would be appropriate in the treatment plan for a service user. We include the following points for consideration when there is a referral requesting direct clinical involvement with a service user:

- Is the service user able and willing to engage in exploratory therapy to develop a potential understanding of the root of their difficulties.

- Has the service user utilised other therapeutic approaches which are less intrusive.

- Is the service user able to tolerate difficult thoughts and feelings which may arise from an exploratory approach; including patience for what may feel like slow progress.

- Are there aspects of a service user's circumstances which may require additional support or stabilisation so that they are able to engage in the therapeutic process.

The following circumstances may also require consideration as factors which may preclude a service user's capacity to make use of an exploratory psychotherapy. Wherever possible we would endeavour to converse with referrers to formulate an understanding before making a decision regarding suitability of assessment or treatment:

- Acuity in clinical risk of harm to self or others
- Acute psychosis
- Substantial Issues with substance misuse which impede engagement and reflective capacity.
- Physical health issues that interfere with the service user's cognitive capacity.
- The service user is involved in on-going legal proceedings.
- The service user is involved in on-going court proceedings in relation to the care of their children.
- The service user is unable to attend regular appointments.

7.1.3. Referral screening and consultation process

Referrals will be allocated by the senior leadership team to practitioners to screen based on factors such as clinician skill mix and capacity. To avoid unnecessary delay in extending waiting times, referral allocation will be delegated within the weekly CIS referral meeting.

Where referral information is missing, the screening clinician, with support from the administrative team where appropriate, will engage proactively with the referrer to detail further information required to progress the referral. Any subsequent delays or inactivity surrounding the referral will be shared by the screening clinician with the senior leadership team who will escalate to support progression in the screening and consultation process.

If the referral is deemed inappropriate at this stage, then the referrer will be consulted with a recommendation for support, including a suggestion of alternative services wherever possible.

For particularly complex clinical presentations, a consultation may be required with the referrer to clarify any aspects of uncertainty regarding the treatment plan underlying the referral, for example to clarify the involvement of other relevant services which form a part of the service user's support system. These discussions facilitate a valuable opportunity to explore pertinent information which may inform further discussions within the referral meeting for decisive action regarding the most appropriate clinical pathway for a service user.

To reflect the referral dialogue between services, the screening clinician will complete the "Internal Transfer" form on Lorenzo. This will support in highlighting any identified actions in the partnership with other services and indicate any areas of disagreement between services which may require escalation to resolve in the best interests of the service user.

Once it is established that a referral is to be accepted, the service user will be placed on the SPS waiting list for an assessment. Whilst there is no mandated timeframe for this process to be completed, SPS is subject to the 4 week wait guidelines and therefore the timeliness of this process is a priority.

7.2. Assessment

The purpose of assessment is to review and confirm the appropriateness of the referral for psychodynamically- informed treatment as per our 4 week pathway. The timeliness of assessment is pertinent as circumstances may change, or new information may come to light regarding the service user's situation or needs from the point of the referral being accepted.

Assessments will be allocated based on factors such as clinical complexity, service user need and a clinician's skill set. Assessment could be generalist or psychodynamic and may take up to 3 sessions. All assessments are required to be presented for case discussion within the weekly MDT meeting to enable a broader professional perspective and consensus in the formulation of a clinical recommendation, which may involve further intervention within the service.

All assessments offered by clinicians will aim to facilitate:

- Collation of baseline clinical outcome measures required in the Mental Health Data Set i.e. DIALOG, ReQoL-10 and Goal Based Outcome measure.

- Review of clinical presentation and any associated clinical risks. On the conclusion of assessment, the assessing clinician will complete an updated copy of the Trusts current clinical risk assessment tool, FACE.

- Formulation of an understanding of a service user's clinical needs and the suitability of psychotherapy as an intervention.

- Where appropriate, the assessing clinician may provide advice and guidance to the service user and their carers (where appropriate) conducive to their expected waiting time for treatment. This may include further referral to other services/ agencies or signposting for support in relation to the wider determinants of wellbeing.

- Consideration of any barriers to accessing treatment; the service will aim as far as possible to find effective solutions.

7.3. Interventions

Pre-therapy

Service users waiting for an exploratory therapeutic intervention may also benefit from an intervention to develop their understanding of what they would like psychotherapeutic work to focus on, to increase their understanding of their current difficulties and to develop ways of coping with these. The service will aim to facilitate a recurring 10-week psychoeducational group which aims to increase understanding in the impact of trauma on the mind and body, include practice of mindfulness and grounding exercises, and introduce the concept of mentalizing (which is informed by aspects of the Mentalization-Based Treatment introductory (psychoeducational) group programme.

Prior to entering the psychoeducational group, services users will be invited to attend individually a pre-group screening appointment over 2 appointment sessions with the facilitators. There is an expectation that service users will be able to commit to attend at a minimum 80% of group sessions. On completion of the group programme, all service users are invited to an individual post-group review appointment to consider their ongoing needs internal and external to the service.

Group facilitators will discuss service user's needs within the weekly MDT meeting where clinically indicated.

Psychotherapy

SPS offers a range of psychodynamically-informed individual and group psychotherapy treatments. These are generally up to 2 years in duration but may be extended where there is an agreed clinical rationale.

The SPS aim to place service users with the most suitable therapist according to specific therapeutic model and according to individual choice and need. Clinicians work collaboratively with the service user around the care plan for their therapy.

Appointments are contracted and planned between service user and therapist. They are usually weekly and on an agreed regular time and day. Some adjustments to therapy times can be made according to need and availability.

It is the expectation that clinicians in the team will present cases for discussion in the SPS MDT meeting during the first 3 months of psychotherapy commencing and 3 monthly intervals, thereafter (see Trust document, MDT Care Planning: Good Practice Guidelines). During the therapy period the therapist will undertake regular reviews of the care plan (minimum 6 monthly), clinical risk assessment and PROMS according to organisational requirements and clinical need.

Towards the end of the therapy period a discharge plan will be undertaken to prepare the service user for discharge and consider any difficulties or needs arising from that. At the point of discharge other services or agencies may be contacted according to need. A discharge letter will be communicated to the GP, service user and other relevant services or agencies as required.

8. Management of escalation in clinical risk presentation or deterioration in condition

Clinical risk assessment skills are built into the training and continuing professional development of all clinicians in the SPS. These skills are an inherent part of the role and routine practice of the clinical functions within the service. The assessment and management of risk will be in line with the Trust Risk Management Policies.

Clinical risk will always be carefully considered at screening and consultation, assessment and continuously reviewed during any subsequent intervention. All psychological practice is designed to prevent or minimise risk. This can be measured, for example, by the reduction of incidents of self-harm, admission frequency, length of admissions etc. during and/or following psychological interventions.

Due to the nature of the service, there may be occasions for clinicians where risk goes beyond what can be contained in “stand alone” psychological work i.e., service users who are not allocated a Care Coordinator/ Case Manager in a Community Mental Health Team (CMHT). In these cases, service users should always be explicitly reminded about additional sources of support that are available to them, and their clinician will always work in liaison with other professionals and agencies as appropriate to form a co-ordinated and individually tailored response to risk. For those who are not in receipt of support within CMHT, SPS clinicians will call professional meetings for service users where needed, for example those who may be difficult to engage and/ present with risk during the course of their treatment requiring multi-professionals’ approach to engagement and risk management.

In the case of service users who are in receipt of CMHT support adjunct to SPS intervention, SPS clinicians will liaise closely with the CMHT to keep the care provision consistent and well-coordinated. This will require SPS clinicians to be invited to care planning meetings where appropriate.

9. Safeguarding

All clinical and non-clinical staff within the SPS are responsible in their own scope of practice to follow relevant Trust policy and procedure in relation to the safeguarding of children and vulnerable adults. Any incidents identified will be recorded and escalated as per Trust protocol.

10. Reporting of incidents

All clinical and non-clinical staff will report incidents via the Trust incident reporting system, Datix. The management of untoward incidents will be led by the senior leadership team and actioned as per Trust Serious Untoward Incidents (SUI) policy.

11. Interface with other internal mental health teams

11.1. Community Mental Health Teams (CMHTs)

SPS does not employ the full range of disciplines often available within a multidisciplinary team (e.g. Occupational Therapy, Psychiatry/ Non Medical Prescribers). Where there is a need for a professional discipline that is not available within SPS for a specific intervention i.e. medical review, social care assessment etc., the identified intervention need will be requested via SPS referral and clinical discussion with the relevant CMHT leads, with the intention that this requested intervention is provided by the CMHT serving the locality in which the service user is based.

11.2. Unplanned care

Service user's on the SPS waiting list, will be provided with a list of out of hour's contacts to ensure 24- hour accessibility to urgent care and support. Service users engaged in therapy are supported to discuss any deterioration in wellbeing or escalation of risk concern in their regular sessions and written in their care plan.

For service users waiting for or engaged in treatment; repeat crisis presentations in a close period may indicate a review of the current treatment and risk management plan is needed. Practitioners will consider whether there are additional support needs which indicate a role for other services or agencies to facilitate stabilisation to enhance and/ or sustain engagement in the therapeutic process.

Due to the planned nature of the service, SPS does not provide a clinical duty system or crisis response or home visit service. If a clinical situation escalates, a referral to other services will be offered while the patient waits for a psychotherapy vacancy, as appropriate. This is because SPS is not an urgent care service, it is for planned, structured treatment and there are other services more appropriate for this type of intervention within the wider mental health service of Humber Teaching NHS Foundation Trust.

The nature of psychodynamically-oriented intervention stresses the importance of regular, routine, structured contact. For this reason, between-session or unplanned contact is unlikely to be effective or appropriate. Service-users should not be redirected to SPS for management of unplanned care/crisis needs. Where they are open to a CMHT, during working hours, service-users should access such support from the CMHT, and unplanned care services as standard outside of working hours. For service-users who are open only to SPS, or do not have an allocated care co-ordinator from a CMHT or equivalent service, service-users are able to self-refer to unplanned care services and should be triaged directly by those services and then supported in line with the MHCIT SOP; access to unplanned care for this group of service-users should not be delayed in order to liaise with or seek approval from SPS clinicians, and SPS are unable to gatekeep unplanned care or follow-up outside of planned contact; however where possible and appropriate to the clinical situation SPS clinicians will be happy to support clinicians from unplanned care in their decision-making.